

CHASE (W.B.)

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Uterine Curette.

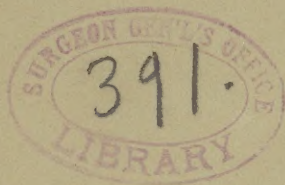
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REMARKS ON
THE USE OF THE UTERINE CURETTE.*

BY WALTER B. CHASE, M. D.,

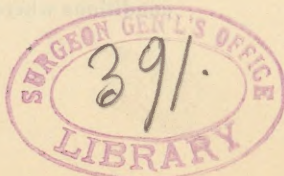
BROOKLYN.

UNDUE prejudice, either the result of imperfect knowledge or conservatism, is, and will continue to be, a barrier to the free acceptance of well-demonstrated truth.

In the medical profession the same rule holds good. Distrust either of well-founded methods, or distrust of one's own self to carry out such methods, often leads to results no less unsatisfactory than boldness without discretion. The question of intra-uterine medication as evinced by the discussion of this hour has not as yet been fully and authoritatively settled.

The topic to which I desire for a few moments to call your attention, while well defined in its limitations and uses, has not as yet received that general acceptance which its utility warrants and which it is destined to receive. It is not my purpose in the brief period of time at my disposal to attempt any exhaustive discussion of the uses of the uterine curette, but to urge its advisability in some important

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but diverse conditions, in the hope that many who from any reason have not acquainted themselves with its advantages may be induced to test for themselves its real utility.

I shall make no effort to differentiate as to what the exact conditions are under which the uterine curette should be used, but shall refer to two or three conditions under which its use is indicated; and I may be permitted to remark that the ordinary reasons which obtain with some as to the contra-indications of intra-uterine medication or intra-uterine instrumentation should not obtain here, and certainly do not in cases which are of puerperal origin.

First will be considered the removal of the placenta after miscarriage. Second, the conditions of puerperal septicæmia from retained placenta or decomposition of blood-clots *in utero*. Third, the scraping away of hypertrophic tissues of the endometrium following labor, either subsequent to miscarriage or labor at full term, as evinced by hæmorrhagia or metrorrhagia, etc. And fourth, the removal of hypertrophic fungosities accompanying so-called chronic endometritis not of puerperal origin.

The requirements to be observed in these several conditions are: First, a proper appreciation of the conditions warranting interference. Second, a strictly aseptic condition of the hands and instrument of the operator. It would appear that no comment need follow this simple statement. Any accoucheur or gynæcologist who exposes his patient to septic influences from contact with hands or instruments would be morally responsible for consequences. Third, a sufficiently patulous uterine canal to admit of the introduction of instruments with sufficient room for thorough irrigation and proper return flow of fluids injected.

Gentleness with thoroughness is a *sine qua non* to successful manipulation in these cases. One of the frequent conditions where the curette is most useful is in cases of

miscarriage in the earlier months of pregnancy. The attendant who finds the fœtus has escaped may also discover that only a portion of the placenta has extruded itself through the external os. Hæmorrhage may or may not be present; if present and active, the need of immediate interference is the more imperative. Here the tampon has been advised and used with varying results, and, if successful, it is no guarantee against sepsis. If properly applied, it may arrest the hæmorrhage; but its proper application is about as difficult as an exploration and emptying of the uterine cavity with the curette. It is under conditions like this that the internal administration of ergot is resorted to with results so contradictory and unsatisfactory as to render it an agent unworthy of our confidence.

To attempt to control the hæmorrhage, the ergot having failed, the attendant may force his hand into the vagina, using his index finger as a curette, passed into the uterine cavity, and if the os is sufficiently dilated he may remove all the placenta; or more likely the fundus, which needs most attention, is just beyond his reach, and the work is imperfectly accomplished, leaving behind the dangers of hæmorrhage as separation takes place, or septicæmia develops as decomposition progresses. Here, with a patient in the Sims position and a Sims' or an Ehrich's self-retaining speculum *in situ*, the cervix is brought into view, and, being steadied by a tenaculum, a blunt curette can be used and every portion of the placental growth removed, after which a hot antiseptic intra-uterine douche should be used, preferably from a large fountain syringe at such a height from the patient as will cause such force of stream as the operator may desire. Ordinarily it is desirable the flow should be gentle, care always being taken to insure the easy return of the counter-current, and this should be continued until the returning fluid is no longer changed by its contact with the uterine

cavity. Apart from the impression imparted to a sensitive hand in the use of the curette the subsidence of hæmorrhage ordinarily marks a properly completed undertaking. No great amount of skill or experience is required to detect with a touch of the curette the location and extent of the placental attachment, and its use is circumscribed to this area. The character of the material removed, together with the quantity, serves as something of a guide in limiting the use of the curette.

Unless it is necessary to forcibly dilate the uterine canal for the purposes of exploration, to which I shall hereafter refer, the administration of an anæsthetic is not always needed. If the patient is excited or of a nervous organization or timid as to endurance of physical suffering, an anæsthetic may be used. If required, unless some contra-indication be present, chloroform is preferred. I recall an instance in one patient where, within the past nine months, I have had occasion to curette the uterine cavity three different times—once for the removal of placenta after a three-months' miscarriage, and twice for the scraping away of fungoid degeneration of the endometrium at an interval of four and five weeks, following a miscarriage of five months where the hæmorrhage was threatening, the patient becoming exsanguinated, rendering interference imperative for the safety of the patient, in which maximum doses of opium, our best and most reliable hæmostatic, failed to control the bleeding only temporarily. In neither instance was dilatation of the uterine canal required, the os being quite patulous. Here the source of the hæmorrhage was limited to the area of placental attachment. After each operation the uterine cavity was thoroughly and persistently douched with a three-per-cent. solution of carbolic acid of a temperature of 115° to 120° F., and so thoroughly was the hæmorrhage arrested and so completely were the mouths of open

blood-vessels closed by the constricting effect of the hot water, that for a period of ten days, in each instance, there was not a drop of discharge from the uterus. I might add, as explanatory of the last hæmorrhage, that, in my judgment, it was due to the debilitating influence and succussion of the pelvic cavity induced by violent coughing from an attack of "la grippe" just as convalescence was established.

An offensive lochia is not a necessary concomitant of puerperal septicæmia (though usually present), and, unless the putrefactive element is evidenced by offensive odor, neither the curette nor the antiseptic intra-uterine injection, are with rare exceptions, indicated. The conditions which might render the use of the curette needful would be the decomposition of retained placenta or membranes *in utero*, or the similar behavior of blood-clots due to imperfect drainage or their coagulation and retention from any cause. In this state, when septic conditions are present, the same precautions should be observed as to the caliber of the cervical canal, and before any instrumental examination is made let the uterine cavity be gently but thoroughly washed with a warm or hot antiseptic fluid. Then, if evidence of decomposing material remains, let the cavity be scraped with a blunt curette, taking care that its form corresponds with the curves of the uterus, which can be ascertained by the passage of a delicate uterine probe. In cases of this nature great gentleness and circumspection should be exercised that no injury be inflicted on the tender tissues of the uterine cavity.

It is desirable to remove all decomposing material; if this is done it may, and probably will, suffice to arrest the further progress of the disease. Such a result would not, however, follow if the infection had passed beyond the superficial structures of the lining membranes of the uterine cavity, having been carried by the lymphatic vessels so that secondary foci of infection had been established, or if the

uterine sinuses were involved. In the latter case, if the septic infection was present in the uterine sinuses, the condition would most probably have passed from septicæmia to pyæmia with the grave complications attending multiple abscess. It is in these conditions of septicæmia from intra-uterine decomposition of removable material that the curette is of such signal value, and it is in this class of cases I desire to urge its employment. If used with reasonable caution, it is not a dangerous expedient, but a safe and conservative procedure. The indications are simple and unmistakable. A decomposing foreign body is present, and its presence is the cause of danger.

If I appeal to the experience of my professional brethren in the treatment of this class of cases, I am confident that their experience will correspond with my own; that a single curetting, with proper douching, will often result in cure.

I desire to report two cases recently under my own observation which have a bearing upon this point, and which are not uncommon in my experience:

The first was that of a primipara, aged about twenty-four whom I saw with a medical friend four days after a difficult labor which was terminated with the forceps, in which were developed chills, high fever, and offensive lochia. The symptoms pointed to decomposition *in utero*. After placing her in the Sims position, a careful examination revealed a uterus six inches in depth containing a mass of decomposing placenta, with some shreds of membrane which was carefully scraped away with the curette, and a hot antiseptic solution was carried to the fundus (while the curette was yet being manipulated) until hæmorrhage was arrested and the returning stream was uncontaminated. The temperature fell promptly, and, though there was some recurrence of the fever, she made a rapid recovery.

A second and quite unusual case of Mrs. M., a multipara aged forty-three years, my own patient, developed the seventh

day subsequent to delivery at full term, every condition appearing normal up to this period, moderately rising fever, sweating, prostration, and offensive brownish lochia. During these seven days there had apparently been no post-partum hæmorrhage, but I was impressed with the belief that there were decomposing blood-clots *in utero*. An examination confirmed my suspicion. Placing the patient on her left side and exposing the cervix with an Ehrich's self-retaining speculum, without any assistance except that rendered by the nurse, no anæsthetic being required, I gently removed with a curette about a pint of broken-down blood-clots, highly offensive, and irrigated the uterine cavity as previously directed.

There were no further untoward symptoms, the lochia lost its septic character, and her convalescence was uninterrupted and satisfactory.

In conditions of septicæmia like those described I am unable to conjecture what other rational and effective method of treatment could be adopted.

I am perfectly confident I have seen in consultation in private practice within a few weeks two fatal cases of septicæmia following miscarriage of two and three months from decomposition of retained placenta which, in all human probability, might have been averted by the timely use of the curette. In one of these cases the curette was used, removing large quantities of broken-down placenta and blood-clots; but the systemic infection was great, the vital powers were exhausted, and the patient died thirty hours afterward. In the other instance no attempt was made to empty the uterine cavity of its septic contents, as the patient had a temperature of 105° F., pulse 160, and rapid respiration, accompanied with great exhaustion, a state which would contra-indicate any operative procedure.

If the instances I have related were isolated experiences, I should feel less positive as to their management.

There is one fact which my own experience confirms,

but which I will not stop here to explain—viz., that puerperal septicæmia is far more prevalent in towns than in the country. The danger both from hæmorrhage and septic infection from the causes already discussed are so great, and the need of proper remedies so imperative, that nothing short of the most certain and effective methods should be adopted.

The measures recommended are so simple and so easily carried into actual use that every general practitioner will find their adoption not merely a matter of expediency, but actual necessity, and in their use will not only find them vastly superior to the tentative means so often followed as regards the safety of the patient, but that it will contribute to his own peace of mind in the consciousness of having neglected nothing which ample experience has demonstrated as of the highest value.

It may be asked whether the curette is advised in the removal of retained placenta at the time of labor at full term. Ordinarily, no. If proper time is given for normal uterine contractions to expel the placenta, associated with the use of well-recognized aids, it is better, if necessary, to gently introduce the aseptic hand for purposes of detaching the placenta, for at this stage the cervical canal is either dilated or easily dilatable.

Of the use of the curette in chronic disease of the endometrium little need be said.

Where fungoid granulations or mucous polypi are present, inducing menorrhagia or metrorrhagia, it is certainly indicated, and excellent results are matters of common experience.

Here the circumstances surrounding each individual case must determine the question of its applicability. The curette is not to be employed in the presence of chronic cellulitis or peritonitis, and, if its use is indicated within

the limitations suggested, the risk of inflammation is very small.

In my individual experience I have, with a single exception, never seen any unpleasant consequences attending its use.

Last summer I had occasion to curette the uterine cavity in a case of menorrhagia, a month or six weeks after a miscarriage, for the removal of fungoid granulations, which was done with proper precautions.

The patient, a young woman of robust constitution, was enjoined strict rest in bed, but, feeling so comfortable, she disregarded my instructions, and, three or four days after the operation, went down stairs and out of doors. This reckless carelessness on her part resulted in a mild attack of pelvic cellulitis, which yielded promptly to appropriate treatment.

So far I have said nothing as to the methods of dilating the cervix before using the curette. It has been stated, on what appears as excellent authority, that a septic condition of the uterine cavity is always associated with an open cervical canal. While I am not prepared to contradict this assertion, it is usually true that no dilatation is required in cases of puerperal septicæmia attended with foetal discharges.

In chronic cases—as disease of the endometrium either succeeding pregnancy or of non-puerperal origin—the necessity of dilatation may be present. At all events, if the curette is used, the os must be sufficiently open to admit the introduction of instruments and to provide for easy irrigation and subsequent drainage. To accomplish this, resort may be had to Hanks's graduated hard-rubber dilators, or an instrument of two blades, like Goodell's, introduced the length of the cervical canal, care being taken not to impinge on the uterine body, which are operated by a screw in the handle like that devised by Goodell.

Here at least one assistant is required, and a second is needed if an anæsthetic is administered. This must be done with strict aseptic or antiseptic precautions, and proper rest in the horizontal position enjoined.

As to the kind of curette used—several of which, together with a variety of dilators, are herewith presented—the individual choice of the operator may be exercised. It is, however, rare that other than a blunt instrument is required. I occasionally use one of copper, fenestrated preferably (silver-plated), and, while small enough to be easily bent with the fingers to the required shape or curve, it should be sufficiently large to resist any force which would bend it in the manipulation. With such a curette, varied in its curves as may be required, every portion of the uterine cavity, unless marked flexion is present, may be gone over, very much as in exploration of the bladder with a sound.

Generally, portions of placenta or fungosities on the fundus and convexity of the uterine cavity are best removed by drawing the curette toward the operator, and those on the concavity by the reverse motion.

The use of the antiseptic solution may be left to the choice of the attendant, as more depends upon the thoroughness of all the manipulation of the operation than to the composition of the irrigating fluid. If any mercuric solution is employed, it should be very weak, and care should be taken to see that it is not retained *in utero*.

I usually use a solution of carbolic acid of about three-percent. strength and hot. The injection may be thrown into the uterine cavity, either with a fountain or a Davidson's syringe, either directly from the nozzle of the syringe or through a large-sized flexible catheter, or a double cannula of sufficient caliber to admit of the passage of small clots or of the *débris* incident to the use of the curette.

On the whole, I prefer the use of a large-sized flexible catheter, so that the current may be directed to any desired part of the cavity, with the curette at the beginning of the douche inside the uterus, to aid in the removal of any loosened portions not previously separated by the curette and too adherent to be washed out by the irrigating current.

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